

United Community Health Center  
630 Ontario Street, Storm Lake, IA 50588

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ MR #: \_\_\_\_\_

In an effort to protect your privacy at all times, we would like to ask for your assistance.

Please provide us with a list of individuals with whom we may discuss your care. The person(s) listed would be able to ask questions regarding your condition. You will not be notified when information is being given to these individuals.

Some of the areas that may be discussed with the person(s) could include treatment options, side effects, prescription management, financial information, test results, etc.

It will be YOUR responsibility to notify United Community Health Center if you wish to ADD or DELETE a name from this list. The information will be maintained in your personal medical record. With out your permission we WILL NOT discuss your care with anyone whose name does not appear on this list.

Please list the names and relationship of the people you wish to allow us to share information about your care with:

Name of Person	Contact Number	Relationship to Patient
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If there are any individuals to whom you NEVER want us to give any information, please also specify those names and relationships:

Name of Person	Relationship to Patient
_____	_____
_____	_____
_____	_____

Signature of Patient or Authorized Person: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_